Medicare Choices

A Medicare beneficiary's guide to options under Medicare

A consumer information guide published by the Office of Insurance Commissioner Deborah Senn

Overview

Medicare+Choice/Medicare Part C

Medicare does not pay 100 percent of all medical bills. Its purpose is to increase access to health care and reduce its financial burden on older, retired or disabled Americans. It offsets medical expenses by providing a basic foundation of benefits, but individuals may still have to pay for some services out of pocket. There are also deductibles, co-payments, and—in some cases—charges over and above what Medicare considers reasonable and necessary, which Medicare will not pay.

All of these expenses have been considered Medicare's "gaps," and most Medicare beneficiaries find they need a plan, policy or program to fill them.

Until now, you could choose from two different ways to fill the gaps in Medicare coverage. You could opt for the fee-for-service system, combining basic Medicare coverage with a Medigap insurance policy and/or employer's retirement plan. Or, you could receive Medicare-covered care through a Medicare managed care plan, if locally available.

The passage of the Balanced Budget Act of 1997 makes available some additional options for filling the gaps in Medicare coverage. In November 1998, new options started to become available in Washington state. All Medicare-enhancing options—the existing ones described in the previous paragraph, along with new choices—now fall under a new "umbrella" called **Medicare+Choice**, or, sometimes, **"Medicare Part C."**

Like the traditional options for enhancing Medicare, any new method will have advantages and limitations, and no option will be right for everyone. Also, not all options will be available in Washington; not all options will be available immediately; and some may change over time.

The most important thing for Washington state consumers to know is that, if you are satisfied with your current situation, **YOU DON'T HAVE TO DO ANYTHING.** If you are happy with your Medigap policy, employer plan, or managed care plan, **THERE IS NO NEED TO CHANGE, AND NO ACTION IS REQUIRED.**

Medicare+Choice options may be modified over time. More detailed information, as it becomes available, can be obtained by consulting a SHIBA (Statewide Health Insurance Benefits Advisors) volunteer trained by expert staff of the Insurance Commissioner's Office. Call **1-800-397-4422** for a referral to the counselor nearest you. For more information about SHIBA, plus a list of publications on Medicare, managed care, and other health insurance options and issues, see the inside back cover of this guide.

This guide is designed to briefly introduce you to all of the Medicare+Choice options, and to summarize their possible benefits and disadvantages. It can help you make sense of information you may receive regarding Medicare+Choice. Use it as you decide what to choose as a first-time enrollee, or to determine whether and when a switch might be worth considering for YOU.

Deborah Senn, Washington State Insurance Commissioner

1. Original Fee for Service

How it works:

Under the "traditional" Medicare system, beneficiaries can use any hospital and see any doctor who accepts Medicare patients, and receive Medicare coverage for any Medicare-approved service. A Medigap policy or employer-sponsored plan is used to fill gaps. The federal Health Care Financing Administration (HCFA) regulates fees. Providers are reimbursed for each service delivered.

Medigap policies—the traditional A through J plans—are offered by insurance companies to fill Medicare gaps. Each plan covers a different grouping of Medicare gaps.

Under Medicare+Choice, two new Medigap policies will be offered beginning October 1998. They will match the standardized plans F & J, but with higher deductibles ($1,500) and thus lower premiums. (Deductibles may change in the future, however.)

Those with insurance through a current or former employer may find that the employer's plan fills Medicare's gaps adequately. Employer plans can be non-standardized, Medigap-*like* policies. **Retirees with employment-related benefits should be cautious about leaving the plan to try any Medicare+Choice option; you may not be able to get back into the employer's plan.**

Advantages:

check

- ☐ Traditional Medicare plus a Medigap and/or employer plan offers freedom—to choose doctors and hospitals, switch at your discretion, and see specialists without referral.
- ☐ Medicare-approved care is covered anywhere in the U.S.; some emergencies are covered (with limitations) in Canada and Mexico and, with some Medigaps, in foreign countries.
- ☐ Medigap policies are guaranteed renewable (cannot be cancelled except for nonpayment of premium).
- ☐ During Medicare-related enrollment periods, Medigap policies are guaranteed issue.

Limitations:

check

- ☐ Routine, preventive, wellness, and alternative care may not be covered.
- ☐ You're only guaranteed issue of a Medigap plan during specific enrollment periods; at other times you may be denied coverage.
- ☐ Some Medigap plans may have up to a 90-day waiting periods for pre-existing conditions.
- ☐ Billings and claims paperwork is your responsibility.

Availability:

This system continues unchanged, with one exception: more flexible enrollment periods under Medicare+Choice offer increased portability (ability to leave a Medigap policy to try one of the newer options, then switch back if desired). For details, contact a SHIBA volunteer (see inside back cover for information).

☐ **YES, I like this option for reasons I checked.**
 # YES boxes checked _____

☐ **NO, I don't like this option for reasons I checked.**
 # NO boxes checked _____

2. HMOS

How it works:

Under Medicare+Choice, health maintenance organizations (HMOs) fall under the heading of **coordinated care**—a category of options also commonly known as **managed care.** Other coordinated/ managed care options, both new and existing, are also covered in this booklet.

HMOs are sometimes thought to represent all managed care, but the HMO is actually only one type of managed care organization (MCO). HMOs do reflect the basic concept of managed care: an organization that provides pre-paid medical and preventive care to enrolled members through a network of doctors, facilities and other health care providers.

Your HMO may maintain its own health center staffed with employees, or it may contract with a group of physicians who treat plan members as well as private patients. In some cases, physicians may belong to more than one managed care organization.

Medicare beneficiaries can receive health care through a *Medicare-contracting* HMO, if one is available in your geographic area. Medicare prepays a monthly amount (the "capitated amount," or "capitation") to the plan on your behalf, and the HMO in turn must deliver all *medically necessary* Medicare-covered treatment.

In addition, the plan may also cover a variety of "extras"—such as preventive or routine care—that would not ordinarily be covered by Medicare.

Depending on the plan, you *may* or may not pay the plan a fixed monthly premium. And you continue to pay your Medicare Part B premium directly to Medicare. Co-payments may be required for some services, but you don't pay Medicare deductibles or coinsurance.

Advantages:

check

- Wellness programs, preventive services and routine care are often covered.
- Often there is little paperwork involved—no bills or claim forms.
- Premiums and co-payments are usually modest, so health care costs are easily budgeted.
- Enrollment cannot be refused based on health or pre-existing conditions (except for End-Stage Renal Disease).
- There are no waiting periods for pre-existing conditions.
- Physicians and facilities are subject to federal quality assurance requirements.

Score your preferences here

Limitations:

check

- ☐ Except for emergency or urgently-needed care, choice of physicians is limited to the plan's staff or network. You assign or "lock in" your Medicare benefits to the MCO; if you want to get Medicare-covered care outside the network, you'll have to pay for it yourself.
  (**NOTE**: Some HMOs may offer a *Point of Service* option, which allows you to go outside the plan's network for some services. In most cases, you'll pay more when you use this option—for example, with a premium, a higher co-payment, a deductible, or by paying for part of the service.)
- ☐ Without referrals from your primary care physician (PCP), specialists are not covered.
- ☐ You must live in a plan's service area to join (except in special cases involving HMO-model employer plans).
- ☐ All services must be obtained within the plan's service area.
- ☐ If you move out of the plan's service area for over one year, your membership will be automatically cancelled.
- ☐ Plans, their Medicare contracts, or network providers can be cancelled.
- ☐ If your physician and your plan decide not to continue working with each other, you may have to change plans or providers.
- ☐ Plans may shut down enrollment periodically to maintain patient/provider ratios.

Availability:

HMOs will continue as they have operated to date.

☐ **YES, I like this option for reasons I checked.**
 # YES boxes checked _____

☐ **NO, I don't like this option for reasons I checked.**
 # NO boxes checked _____

3. PPOS

How it works:

Like HMOs, Preferred Provider Organizations (PPOs) are a Medicare+Choice **coordinated care** option. These options differ from each other in two key ways: who administers them, and to what degree a member is required to receive care from plan staff or affiliated providers. The PPO model is administered by an insurance company, and it allows more freedom than an HMO to seek care outside the network—but at a cost.

A PPO is a network of providers who contract to provide services at pre-negotiated rates. Enrollees may go outside the network for services if they're willing to pay more. The plan pays a higher percentage of costs when you use its "preferred providers," less if you go outside the plan to a non-preferred provider.

While PPOs exist in the general insurance market, often in employer plans, there aren't yet any Medicare-contracting PPOs in Washington. Under Medicare+Choice, it is anticipated that PPOs will work the way other managed care plans have worked with Medicare: Medicare prepays a monthly amount to the plan on your behalf; you may pay a fixed monthly premium; you'll continue to pay your Part B premium directly to Medicare. The PPO will be required to deliver all *medically necessary* Medicare-covered care.

You won't pay Medicare deductibles or coinsurance, but the plan may have its own deductibles or coinsurance. For example, it may pay 90% of the approved amount for a preferred provider's service, but 60% for that of a non-preferred providers. It may start paying its share after the first $100 of medical expense annually.

Advantages:

check

- ☐ You can use your Medicare benefits outside the plan (have Medicare and the plan pay a share of Medicare-covered care even if you go outside the affiliated provider network).
- ☐ You may be able to self-refer to specialists or other providers without a primary care physician referral.
- ☐ You can reduce out-of-pocket expenses by seeing preferred providers.
- ☐ At this point the underwriting structure for Medicare PPOs is not established, so it is unclear whether they may impose waiting periods or will be guaranteed issue.

Limitations:

check

- ☐ Though care from a non-affiliated provider will be covered, you will pay more for it.
- ☐ A PPO, its Medicare contract, or provider contracts may be cancelled.
- ☐ If your physician and the plan decide not to continue working together, you may have to change plans or doctors.
- ☐ It's not yet established whether Medicare PPOs will have limited service areas. (In other types of managed care, members must live in and obtain services from a plan's service area. Moving out of the service area for one year or more automatically cancels membership).

Availability:

The Balanced Budget Act of 1997 provides for Medicare, for the first time, to contract directly with PPOs. Companies in Washington may—or may not—choose to contract as Medicare PPOs.

☐ **YES, I like this option for reasons I checked.**
 # YES boxes checked _____

☐ **NO, I don't like this option for reasons I checked.**
 # NO boxes checked _____

How it works:

Under Medicare+Choice, physicians and hospitals will be allowed to create their own organizations to contract with Medicare, the way HMOs and PPOs do. These provider-sponsored organizations—PSOs—are new, and yet another **coordinated care** option under Medicare+Choice.

Coordinated care options differ chiefly in terms of who administers them and to what degree members are required to receive care from plan staff or affiliated providers. A PSO will be owned and operated by the providers themselves: the doctors and other practitioners who give the care. PSOs are likely to be as restrictive as HMOs regarding lock-in to receiving care from the network. (See HMOs, #2 in this booklet.)

It is anticipated that in most ways, PSOs will work the way other managed care plans have worked with Medicare in the past: Medicare will prepay the monthly capitation to the plan on your behalf, you may or may not pay a fixed monthly premium, and you will continue to pay your Part B premium directly to Medicare. The PSO will be required to deliver all *medically necessary* treatment covered by Medicare. Co-payments may be required for some services, but you won't pay Medicare deductibles or coinsurance.

Advantages:

check

- ☐ The providers who treat you will make decisions about care free from oversight by a separate managed care organization.
- ☐ As with most managed care, there will probably be little paperwork (no bills and claims forms).
- ☐ Deductibles and co-payments will probably be modest.
- ☐ Enrollment cannot be refused based on health or pre-existing conditions during specified enrollment period (except for End-Stage Renal Disease).
- ☐ There probably won't be waiting periods for pre-existing conditions.

Limitations:

check

- ☐ Plan stability could be a concern if providers who are not experienced in health plan administration must manage the plan as well as provide the health care.
- ☐ Except for emergency or urgently-needed care, you'll have to see the plan's providers. You'll lock your Medicare benefits into the plan; if you want care outside the plan, you'll have to pay for it yourself.
- ☐ A specialist will not be covered without referral from your primary care physician (PCP).
- ☐ As with all managed care, plans or their Medicare contracts may be cancelled.
- ☐ If your physician and the plan choose not to keep working together, you may have to change plans—or doctors.

Availability:

PSOs are provided for by the Balanced Budget Act of 1997. Providers in Washington may or may not form PSOs.

☐ **YES, I like this option for reasons I checked.**
 # YES boxes checked _____

☐ **NO, I don't like this option for reasons I checked.**
 # NO boxes checked _____

5. Religious/Fraternal

How it works:

Under Medicare+Choice, organizations with members—such as churches or associations—may contract with providers for health care services in a coordinated care setting. (See option 2/HMOs for more on coordinated care.) Enrollment will be open only to members of the group that sponsors the plan. These plans will be known as Religious Fraternal Organizations (RFOs).

Advantages:

check

- ☐ You may be able to get your managed care from an organization you care about, to which you want to contribute, and which reflects your values or beliefs.
- ☐ Managed care involves less paperwork than fee-for-service (virtually no bills and claims forms).
- ☐ Premiums and co-payments may be modest compared to fee-for-service systems.
- ☐ Enrollment cannot be refused based on health or pre-existing conditions during specified enrollment period (except for End-Stage Renal Disease).
- ☐ There may not be waiting periods for pre-existing conditions.

Limitations:

check

- ☐ You must be a member of the group to join the plan.
- ☐ Plan stability could be a concern unless the organization is experienced in administering a health care plan.
- ☐ As with other managed care, your choice of physicians will be limited to the plan's provider network. You will lock your Medicare benefits into the plan, and if you get Medicare-covered care from a non-affiliated provider, you'll have to pay for it yourself.
- ☐ It is anticipated that, as with other managed care, specialists will only be covered with referral from a primary care physician (PCP).
- ☐ As with other managed care, there may be a plan service area in which you must live to join, and in which all covered care must be received. If you move out of the plan's service area for one year or more, your membership is automatically cancelled.
- ☐ The plan or its Medicare contract may be cancelled—it won't be "guaranteed renewable."
- ☐ If your physician and the plan decide not to continue working with each other, you may have to change plans—or doctors.

Availability:

RFOs are provided for by the Balanced Budget Act of 1997. Groups in Washington may or may not form RFOs.

☐ **YES, I like this option for reasons I checked.**
 # YES boxes checked _____

☐ **NO, I don't like this option for reasons I checked.**
 # NO boxes checked _____

6. Private Fee-For-Service

How it works:

In the "traditional" Medicare system, beneficiaries and Medicare share costs on a per-service basis for Medicare-approved, medically necessary services from any provider. Beneficiaries using this "fee-for-service" system may use Medigap policies—the traditional A through J plans—to help pay for their share of costs. Or they may use an employer's retiree plan to fill Medicare's gaps and pay part of their out-of-pocket expenses.

An additional new fee-for service system under Medicare+Choice, called Private Fee-For-Service plans, will combine some of the advantages of "government-issue" Medicare with those of private insurance. In this system, Medicare beneficiaries can buy plans from insurance companies that cover both Medicare-covered services and supplemental coverage. The companies will be paid by Medicare to cover your Medicare benefits (the same regional "capitation" it would pay to a managed care plan on your behalf).

You'll continue to pay Part B premiums to Medicare, and you'll also likely pay a premium directly to the insurance company for the plan. Premiums won't be limited, and Medicare's payment to the company on your behalf probably won't cover the total cost of the plan. In effect, you and Medicare will share the plan cost.

In return, the plan will cover all Medicare-covered care from any provider. In order to compete, companies will likely enhance the basic Medicare package with varying additional benefits. This means the plan may cover some Medicare gaps, prescriptions, preventive and routine services, and/or alternative therapies.

Advantages:

check

- ☐ Like traditional Medicare-plus-Medigap-and/or-employer-plan, this system offers freedom—to choose doctors and hospitals, switch providers at your discretion, see specialists without referral, and move or travel without losing coverage or having to pay extra.
- ☐ The policies ***may*** cover extras not normally covered by Medicare or even some Medigaps, such as alternative providers or prescription drugs. This could offer some of the extra benefits of a managed care plan without the restrictions.
- ☐ The policies may offer guaranteed renewability and/or guaranteed issue.

Limitations:

check

- ☐ Currently, there are no ceilings on premiums.
- ☐ Benefit packages will not be standardized, so it will be important to compare policies carefully to be sure all the gaps you need filled are covered.
- ☐ Doctors will not be subject to Medicare's limiting charge (maximum they can charge you) for services, so out-of-pocket expenses may be significant.
- ☐ Some plans may only guarantee issue during specific enrollment periods.
- ☐ Plans may have waiting periods for pre-existing conditions.
- ☐ Billings and claims paperwork may continue to be your responsibility.

Availability:

No private fee-for-service plans exist yet in Washington; insurance companies may or may not offer them.

☐ **YES, I like this option for reasons I checked.**
 # YES boxes checked _____

☐ **NO, I don't like this option for reasons I checked.**
 # NO boxes checked _____

7. Medical Savings Accounts

How it works:

MSAs are tax-free bank accounts which hold money earmarked for health care. Under Medicare+Choice, the government will create *Medicare* Medical Savings Accounts (there are also non-Medicare MSAs) on a demonstration basis. Enrollment is limited to 390,000 Medicare beneficiaries nationwide.

A Medicare MSA offers two sources of coverage for health care expenses: the account itself, and a high-deductible (maximum $6,000) insurance policy that backs it. Account funds are available for any medical expense until the deductible is met; after that, the policy covers 100 percent *of allowed charges for Medicare-approved care* (plus Medicare deductibles and coinsurance). Additional coverage or restrictions may vary from plan to plan.

The account itself is funded by Medicare's annual contribution, determined by your area's **"capitation"* less** the amount Medicare will pay monthly for your MSA's insurance premiums. (Premiums will vary by plan.)

You pay your Part B premium directly to Medicare. If medical expenses exceed your MSA funds for that year, you must pay those expenses until the insurance deductible is met. Unspent funds amass in the account and are carried to the next year. Upon the beneficiary's death, all remaining funds become the property of his/her estate.

*Medicare's ***capitation*** is the amount it pre-pays on your behalf to any plan in which you enroll. It varies from region to region, based on the average monthly cost for a person in a given age group and geographic area (Average Annual Per Capita Cost, or AAPCC). Every Medicare+Choice option is "capitated" the same amount on your behalf; what differs from plan to plan is who gets paid and when. See other pages of this guide for more on how Medicare pre-pays specific plans.)

Advantages:

check

- ☐ MSAs offer the opportunity to partly self-insure, yet have the safety net of insurance underneath.
- ☐ If medical expenses are low, you can keep and save unspent portions of Medicare's capitation (instead of having that money paid to, controlled by, and kept by a plan whether or not you incur expenses).
- ☐ Account funds are not taxable as long as they're withdrawn only for qualified medical expenses.
- ☐ *If* the MSA's insurance policy is a fee-for-service/indemnity-type plan, you can freely choose or switch doctors and hospitals, specialists, health services, and types of care. (Be aware when evaluating MSAs that the backup insurance varies by plan; if it's a coordinated care-type plan, there may be managed care-type restrictions.)
- ☐ Account funds can be used for medical expenses not covered by Medicare (e.g.,prescriptions, long-term care).

Limitations:

check

- ☐ You can only disenroll once a year.
- ☐ If medical expenses exceed Medicare's contribution to your MSA, you pay out of pocket till deductible is met.
- ☐ While *account* funds can be used for any qualified medical expense, the backup insurance covers only *allowed charges for Medicare-approved care* (plus Medicare deductibles and coinsurance). You'll owe any excess charges.
- ☐ MSA funds withdrawn for anything but qualified medical expenses are subject to taxation and other penalties.
- ☐ Some beneficiaries—such as hospice patients, Medicaid recipients, and federal retirees—are not eligible.

Availability:

This is a pilot project, with limited enrollment starting in 1999 to about one percent of Medicare beneficiaries.

☐ **YES, I like this option for reasons I checked.**
 # YES boxes checked _____

☐ **NO, I don't like this option for reasons I checked.**
 # NO boxes checked _____

Evaluate your highest-rated options

If you checked that you...

- want to move or travel as you wish, without losing benefits or having to pay out of pocket
- want to see specialists as you wish
- want to choose or change doctors freely

Then consider...

- the standard Medicare fee for service system combined with a Medigap policy or an employer's plan OR
- Medicare plus one of the new private fee-for-service plans OR
- A Medical Savings Account

If you checked that you...

- need to know in advance what your out-of-pocket expenses for health care will be
- want to have one doctor and one organization coordinating all of your care, even when you see specialists or other providers
- want to avoid dealing with Medicare claim forms and doctor bills

Then consider...

- Medicare Managed Care / Coordinated Care:
  HMOs
  PPOs
  PSOs
  RFOs

Also be sure to check whether your plan offers other features you may want or need:

- Prescription coverage
- Doctors with autonomy
- Guaranteed issue and renewability.
- Foreign travel
- Alternative providers
- No waiting periods

Remember, if you're satisfied with your current situation, YOU DON'T NEED TO DO ANYTHING ABOUT MEDICARE+CHOICE. Even if you wish to consider one of the new options, you don't need to do anything right away. Consult a SHIBA volunteer for late-breaking information on Medicare+Choice options, availability, enrollment, and other Medicare changes.

See back cover for information about SHIBA (Statewide Health Insurance Benefits Advisors.)

IF YOU NEED MORE HELP:

SHIBA is a ***free*** public service sponsored by Insurance Commissioner Deborah Senn's office. It's an impartial, confidential resource to help you evaluate, choose, and use your health insurance wisely.

A statewide network of volunteers, trained by Commissioner's Senn's expert staff, stands ready to educate you on health insurance issues, so you can make informed decisions.

Our highly trained counselors have up-to-date information on most health insurance concerns. They can answer questions and assist with insurance planning.

SHIBA's services are ***free***. And our volunteers have ***no*** affiliation with any insurance company or product.

SHIBA was the first program of its kind in the U.S., and is now a model for other programs nationwide.

There's a SHIBA unit in nearly every county in Washington State. Call today to get the number of the SHIBA sponsor nearest you.

1-800-39-SHIBA

(1-800-397-4422)

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SEE ALSO:

These SHIBA publications for Medicare beneficiaries, seniors, pre-retirees and disabled individuals

- Medicare, Medigap & You
- Managed Care, Medicare & You
- Retirement & Your Health Insurance
- Managing Your Managed Care
- Consumer's Guide to Financing Long-Term Care

And these general (non-Medicare) fact sheets by the Office of the Insurance Commissioner

- Health Insurance Fraud Costs You
- Access to Alternative Health Care
- Women's Direct Access to Health Care Provider
- Buying Health Insurance in Washington State

HELPFUL NUMBERS:

SHIBA Hotline / (800) 397-4422 **http://www.wa.gov/ins**
Insurance Commissioner's Consumer Hotline / (800) 562-6900
(for all insurance—life, auto, homeowners, etc.)

Social Security Administration / (800) 772-1213

Health Care Financing Administration (HCFA)
Consumer Services (206) 615-2354
Medicare Hotline (800) 638-6833
Medicare Managed Care (206) 615-2351

National Committee for Quality Assurance (202) 955-3500

Rating/accreditation info (managed care plans) (800) 839-6487
Washington State Medical Quality Assurance Commission
(360) 753-2287 professional record info on doctors
(360) 586-8438 professional record info on osteopaths

Medicare Part A & B Intermediaries & Carriers
Blue Cross Part A Fiscal Intermediary (206) 670-1010
Mutual of Omaha Part A Fiscal Intermediary (402) 351-2860
Noridian - Part B Carrier (800) 444-4606
Peer Review Organization (PRO) (206) 368-8272, (800) 445-6941